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Health Plan Transparency Final Rule Requires New Health Plan Disclosures

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On October 29, 2020, the Department of Health and Human Services (HHS), Department of the Treasury (Treasury) and Department of Labor (DOL) issued the final rule on transparency in health plan coverage. The final rule imposes significant new requirements on group health plans, including all issuers of non-grandfathered individual and group health insurance coverage and self-insured plans (that are not account based plans), to disclose information on pricing and cost-sharing under their plans. Grandfathered health plans and excepted benefit health plans are not subject to the transparency rules.

The Affordable Care Act requires group health plans and health insurance issuers to comply with certain transparency requirements. The preamble to the final rule indicates that Congress's intent behind the transparency requirements is to promote and support an efficient and competitive health care market and give participants the information necessary to make informed decisions about health care purchases. In the summer of 2019, President Trump issued Executive Order 13877, which leveraged the Affordable Care Act requirement, and directed HHS, Treasury and DOL to solicit comments on how insurers and group health plans could be required to provide or facilitate access to information about charges for health care services and expected out-of-pocket costs for participants before receiving health care. The agencies published the proposed rule in mid-November 2019. The final rule is the culmination of this effort. Its requirements include:

Effective Date:	Transparency Requirement
Plan years beginning on or after **January 1, 2022**	*Public Disclosure.* Group health plans must make available to the public machine-readable files (updated monthly) that disclose three sets of information: 1. In-network negotiated rates for all covered items and services between the plan/issuer and providers 2. Out-of-network allowed charges and billed amounts during a recent 90-day period

	3. In-network prescription drug negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level.
Plan years beginning on or after **January 1, 2023** *Plan years beginning on or after* **January 1, 2024**	*Required Disclosures to Participants.* Group health plans must make cost-sharing information available through a self-service tool on an internet website that provides real-time responses based on up-to-date cost-sharing information, and in paper form upon a participant's request. Effectively requiring an "advance EOB," this requirement phases in as follows: Group health plans must make the self-service tool available for 500 items and services determined by the agencies. Group health plans must make the self-service tool available for all covered services.
2020 MLR reporting year	Health insurance issuers that introduce new or different plans that include provisions encouraging consumers to shop for services from lower-cost, higher-value providers, and that share the resulting savings with consumers, are permitted to take credit for such "shared savings" payments in their medical loss ratio (MLR) calculations. Under the MLR rules, insurers are required to pay rebates to groups when the MLR falls below specified thresholds (generally, 80 percent in the individual and small group markets and 85 percent in the large group market).

Compliance with the new transparency requirements will require significant preparation for both employers sponsoring self-funded group health plans and health insurance issuers. The election and possible legal challenges may impact the implementation of this final rule. Please watch for our client alert coming soon with more details on these requirements and considerations.

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